Patient Information

PLEASE PRINT

NAME ______________________________ DATE ____________

DOB ____________ SS# ____________ AGE ________ SEX M ___ F ___

ADDRESS ______________________________ CITY ____________ ZIP ________

HOME PHONE ____________ WORK ____________ CELL ____________

FAMILY PHYSICIAN ____________ REFERRED BY ____________

IF PATIENT IS A MINOR
PARENT/LEGAL GUARDIAN ______________________________ DOB ____________

SS# ____________ PHONE# ____________ SEX M ___ F ___

ADDRESS ______________________________ CITY ____________ ZIP ________

EMPLOYER ____________ PHONE# ____________

IN CASE OF EMERGENCY, CONTACT (Other than spouse) ____________

RELATIONSHIP ____________ PHONE ____________

INSURANCE INFO
RESPONSIBLE PARTY ____________ RELATIONSHIP ____________
(If different from patient)
DOB ____________ SS # ____________

PRIMARY Name of Carrier ____________ ID# ____________
Account/Group# ____________

SECONDARY Name of Carrier ____________ ID# ____________
Account/Group# ____________

We ask all patients to show their insurance cards and ID so that we can make copies of them for out records.
We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, who is primarily responsible for payment. As a courtesy we will prepare any necessary reports and itemizations to assist in making collections to the patient's account.

Payment Authorization

I hereby authorize Eyes of Texas, LLP to furnish information concerning my present illness to my insurance company. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due as a result of a claim. **Although covered by insurance, I am aware that I am responsible for all charges.** A photocopy of this authorization will be as valid as the original.
By signing below I have read the above agreement and understand my liability to Eyes of Texas, LLP.

______________________________ ____________

Responsible Party Signature Date

PATIENT HISTORY / V72.5

NAME: ______________________ DATE: ______________ ACCOUNT #: ______________

REVIEW OF SYSTEMS:

Do you currently have any of the following problems?	YES	NO	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	
Ear/nose/throat (e.g., hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing or coughing)	☐	☐	
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea)	☐	☐	
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g., rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (e.g., depression, anxiety)	☐	☐	

MEDICAL STATUS:

- Have you been treated for any medical conditions? (e.g. diabetes, high blood pressure, arthritis, etc.)

  ☐NO ☐YES please explain: ______________________
- Have you ever had any surgery?

  ☐NO ☐YES please explain: ______________________
- Do you take any medications?

  ☐NO ☐YES please explain: ______________________
- Do you have any drug or food allergies?

  ☐NO ☐YES please explain: ______________________

OCULAR HISTORY: Have you ever been diagnosed with any of the following?

YES	NO		YES	NO	
☐	☐	Cataracts ______	☐	☐	Cornea Disease ______
☐	☐	Retina Disease ______	☐	☐	Glaucoma ______
☐	☐	Iritis ______	☐	☐	Injury ______

Other ______________________

☐ ☐ Cataract surgery? Left eye (date)______________ Right eye (date) ______________

FAMILY HISTORY: Has anyone in your family (blood relative) had any of the following?

(NOTE: RELATION TO PATIENT. F-Father, M-Mother, S-Sister, B-Brother, GF-Grandfather, GM-Grandmother, U-Uncle, A-Aunt.)

YES	NO		YES	NO	
☐	☐	Glaucoma ______	☐	☐	Diabetes ______
☐	☐	Cataracts ______	☐	☐	Heart ______
☐	☐	Cornea Disease ______	☐	☐	Diabetic Retinopathy ______
☐	☐	Macular Degeneration ______	☐	☐	Retinal detachment ______
☐	☐	High blood pressure ______	☐	☐	Stroke ______

Other health problems? ______________________

The reason for your visit today Is?________________________________

____

Please circle yes or no to the following question

Do you have diabetes?	No	Yes
Do your eyes itch?	No	Yes
Do your eyes burn?	No	Yes
Do your eyes water?	No	Yes
Do your eyes get blurry?	No	Yes
Do your eyes get tired?	No	Yes
Do your eyes seem red?	No	Yes
Do you experience eye irritation or discomfort?	No	Yes
Do you have trouble seeing at night?	No	Yes
Do you have any discharge coming from your eye?	No	Yes

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Please Print Name

____
Patient Signature

____
Date

____
Personal Representative Signature

____
Personal Representative's Authority

Financial Policy

Please read, and then indicate your preferred payment plan option at the bottom of this page. We will gladly explain our fee schedule.

Payment Plans

1. Payment of the total fee on the day of visit by cash or check.
2. Charge cards: Visa/MasterCard/American Express/Discover.
3. Pre-Authorized Insurance (We must be able to verify coverage.)
   - Insurance coverage: Your insurance policy is a contract between you and your insurance responsibility whether your insurance company pays or not. Even though an insurance claim is filed, you will receive a statement each month, if your account has a balance due. If your insurance has not paid in full within 45 days, the balance automatically becomes your responsibility and payment is expected within 10 days of receiving your statement. Please be aware that some, and perhaps all, of the services provided may be "non-covered" and may not be considered under your health care insurance. In regards to Usual, Reasonable, & Customary Rates, our practice is committed to providing the best responsible for payment in full. Regardless of your insurance company's arbitrary determination of usual and customary rates.

Please initial each of the following statements:

- Our office cannot accept responsibility for collecting your claim or for negotiating a settlement on a disputed claim.

  Initial __________

- If an insurance claim is not paid within 45 days, payment of the balance due becomes your responsibility.

  Initial __________

Please let us know if you have any questions or concerns. Please indicate your choice of payment by signing the following statement and circling the chosen payment plan #.

Please circle ONE of the following payment plans: #1 #2 #3

______________________________ ______________________________

Signature of Patient/Guardian Date

Patient Authorization for Appointment Reminders and Scheduling

It is the desire of our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you of your scheduled appointments, re-evaluations, or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information for this reason, your decision will have no adverse effect on your care from The Eyes of Texas or your relationship with our staff.

Your signature indicates your authorization of this activity.

____
Patient Name (Print)

____________________________________ ____________________________
Patient Signature Date

You may revoke this authorization at any time. Please let us know in writing.